

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/07/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155788		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 09/16/2011	
NAME OF PROVIDER OR SUPPLIER GREENWOOD MEADOWS, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 NORTH STATE ROAD 135 GREENWOOD, IN46142			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	<p>This visit was for the Investigation of Complaints IN00095560 and IN00096047.</p> <p>Complaint IN00095560 -Substantiated. Federal/ State deficiencies related to the allegations are cited at F280 and F323.</p> <p>Complaint IN00096047 -Substantiated. Federal/ State deficiencies related to the allegations are cited at F280.</p> <p>Survey dates: September 15, and 16, 2011</p> <p>Facility number: 012564 Provider number: 155788 AIM number: 201018510</p> <p>Survey team: Christine Fodrea, RN</p> <p>Census bed type: SNF: 41 SNF/NF: 17 Total: 58</p> <p>Census payor type: Medicare: 28 Medicaid: 8 Other: 22 Total: 58</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0280 SS=E	<p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 20, 2011 by Bev Faulkner, RN</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to update care plans for 6 of 6 residents reviewed; 3 of 6 residents reviewed for feeding strategy care plan updates (Resident #C, Resident #F, and Resident #G) and 3 of 6 residents reviewed for fall care plan updates (Resident #B, Resident #D, and Resident #E) in a sample of 6.</p>			F0280	<p>F280: Itti is ttihe practtice off ttihiis provider ttio develop a comprehensive care plan wittihir7 days off admission by ttihe proffiessional Inttierdisciplinary ttieam and ttihatti itti is reviewed and revised as is indicattied by changes in ttihe residentti's assessmenttti</p> <p>Whatt correcttve actto(s) will be accomplished fiior tthose residentts fiound tto be affectted by tthe alleged deficientt practtce Residentts F G,</p>		10/02/2011

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	<p>Findings include:</p> <p>1. Resident #C's record was reviewed 9/16/2011 at 11:29 a.m. Resident #C's diagnoses included but were not limited to high blood pressure, osteoarthritis, and cancer.</p> <p>Resident #C had a physician's order to be seen by speech therapy on 7/27/2011. A speech therapy note, dated 8/26/2011, indicated Resident #C needed cues to use swallowing strategies.</p> <p>A review of care plans dated for Resident #C, dated 8/8/2011, included he had swallowing difficulties, but the care plan did not include cueing to assist with swallowing.</p> <p>2. Resident #F's record was reviewed 9/16/2011 at 10:30 a.m. Resident #F's diagnoses included but were not limited to dementia, chronic kidney disease, and depression.</p> <p>Resident #F's speech therapy note, dated 9/9/2011, indicated Resident #F was to be given verbal cues for chin tuck and double swallow.</p> <p>A review of care plans for Resident #F, dated 6/14/2011, revealed he had a risk for aspiration, but the care plan did not</p>				<p>D, and E Resident Comprehensive Care Plans have been updated with current interventions. The interdisciplinary professional team has met to review and update all care plan interventions related to this citation. All residents care plans have been completed. See corrected copies attached.</p> <p>1. Resident C had been discharged from this facility 8/28/2011 prior to the September Survey Event.</p> <p>2. Resident B was admitted on June 28, 2011 and discharged within six hours of admission on June 28, 2011, also discharging prior to the September Survey Event.</p> <p>How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken? All residents with Fall Risk or Speech patients recommended for compensatory strategies related to eating/swallowing could be affected by this documentation error of omitting recording this information in the Resident's Comprehensive Care Plan. The interdisciplinary professional team have participated in and reviewed all current inpatient Resident's Comprehensive Care Plans updating current interventions and related goals. The Nursing Staff has been informed of the changes in the Resident's Comprehensive Care Plans.</p>		

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	<p>include chin tuck and double swallow.</p> <p>During an observation of Resident #F on 9/16/2011 at 7:45 a.m., he was noted to be sitting in the main dining area, eating a pureed diet with pudding thick liquids. he was not being cued to double swallow or use chin tuck. He had no coughing or sneezing during the meal.</p> <p>3. Resident #G's record was reviewed 9/16/2011 at 8:55 a.m. Resident #G's diagnoses included but were not limited to high blood pressure, depression and epilepsy.</p> <p>Resident #G's speech therapy note, dated 9/9/2011, indicated Resident #G needed verbal cues to use tongue sweeps or liquid washes to clear residue.</p> <p>A review of care plans for Resident #G, dated 8/24/2011, revealed she had a mechanically altered diet related to swallowing difficulties, but the care plan did not include needing cues to clear the residue in her mouth.</p> <p>In an observation on 9/16/2011 at 7:45 a.m., Resident #G was sitting in the main dining area with the Speech Therapist who was cueing her to clear her mouth.</p> <p>In an interview with the Speech Therapist</p>				<p>and during each shift report the system each staff member is advised of new interventions. Shift report is conducted by the Licensed Charge Nurse on each unit. Resident Comprehensive Care Plans C.Q.I. audit tool will be used as the monitoring tool and completed daily X5, weekly x4, and monthly x2. The quarterly floor quarters if established thresholds are not met the results of this will be reviewed by the C.Q.I. committee and Medical Director with an Action Plan developed to address these thresholds. The C.Q.I. tool will be monitored by the Director of Nursing Service and the results reported to the Executive Director.</p> <p>Page 2 Plan of Correction – Greenwood Meadows Survey Event# ZWW111 F280 Continued.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur</p> <p>All interdisciplinary team members and Licensed Nurses have been in-serviced on the facilities policy and procedure regarding Resident Comprehensive Care Planning. (See Attachment) All clinical nursing staff have been in-serviced regarding acceptable compensatory strategies by the Rehabilitation Services Manager/Licensed Therapist. These are included in the treatment plan and Resident's Comprehensive Care Plan.</p>		

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	<p>on 9/16/2011 at 9:50 a.m., he indicated speech therapy was not always in the dining area with Resident #G and the staff had been instructed on her swallowing strategies. Additionally, Resident #G's swallowing strategies were outlined on a list available to the staff.</p> <p>A copy of the swallow strategy list available to the staff provided by the Director of Nursing on 9/16/2011 at 9:55 a.m., revealed swallowing list did not include Resident #G.</p> <p>4. Resident #B's record was reviewed 9/15/2011 at 5:00 p.m. Resident #B's diagnoses included but were not limited to dementia, depression, and anxiety.</p> <p>Resident #B's nurse's notes dated 6/28/2011 at 9:10 p.m., indicated Resident #B fell in the doorway of her room.</p> <p>Resident #B's fall risk assessment revealed two assessments completed on 6/28/2011 both indicated the resident was at risk for falls.</p> <p>A review of care plans, dated 6/28/2011, for Resident #B revealed she was at risk for falls related to dementia, but the care plan did not include history of recent falls or interventions to prevent falls from occurring.</p>				<p>. The Inttierdisciplinary Team is monittoring tti these changes ttio ensure tti the Residentti Comprehensive Care Plans are updattied ttihrough tti the morning clinical meettings Unitti Manager and Licensed Charge Nurses are daily reviewing tti these changes ttihrough individual monittoring ofi Unitti Rounds and Unitti Shifi Change each shifi .</p> <p>How tthe correctve actto(s) will be monittored ttio ensure tthe deficientt practtce will nott reoccur Residentti Comprehensive Care Plans C.Q.I. auditti ttiool will be utilized as tti the monittoring ttiool and completted by tti the Assittiantti Directtior ofi Nursing daily X5, weekly X4, and montthly X ttihan quarttlerly fto quarttlersfi accepttiable ttihresholds are notti metti tti the resulttis will be reviewed by tti the C.Q.I. committtee and Medical Directtior wittih an action plan being developed and implementtied In-services (stti afi educattio) have been conducttied regarding Residentti Comprehensive Care Plan Policy and Procedure Review (conducttied by tti the M.D.S. Licensed Nurse Manager on 9/27, 9/28 and 9/29 for Licensed Nurses, Inttierdisciplinary Team Members and Speech, Occupattional and Physical Therapisttis – see atttachmenttis ofi tti mstti endance conttientti wittih tti the means ttio assess learning/tti estt Compensattioy Inttierventio(s) conducttied by tti the Rehabilittatio Services Manager and Speech Therapistti on 9/26, 9/27 and</p>		

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	<p>In an interview with LPN #1 on 9/16/2011 at 9:09 a.m., she indicated the family had not indicated Resident #B was at risk for falls and had not fallen since January. She additionally indicated she had updated Resident #B's fall risk assessment when she had obtained additional information. When informed Resident #B had fallen on 6/11/2011 at a previous residence, LPN #1 indicated she would have put more interventions in place to prevent falls.</p> <p>5. Resident #D's record was reviewed 9/15/2011 at 2:10 p.m. Resident #D's diagnoses included but were not limited to dementia, depression, and anemia.</p> <p>Resident #D's nurse's notes indicated he had fallen from his wheelchair on 8/23/2011 at 9:50 a.m.</p> <p>A review of Resident #D's nurse's notes revealed he had silenced the alarms on 8/22/2011 and 9/3/2011.</p> <p>A review of the fall circumstance report, dated 8/23/2011, indicated new intervention to be put into place was to cue Resident #D to lay down.</p> <p>Resident #D's fall care plan, dated 8/19/2011, included interventions of bed and chair alarms as well as a low bed with</p>				<p>9/28 for Licensed Nurses and C.N.A.'s – see attachment of times attendance content with the means to assess learning and Accident/Fall Prevention and Intervention conducted by the Licensed Nurse Unit Manager for Licensed Nurses and C.N.A.'s on 9/27, 9/28 and 9/29 –see attachment of times attendance content with the means to assess learning/times Educational programs were presented multiple times for increased staff attendance. Updated N.A. assignment sheet with current interventions will be monitored daily by the Licensed Charge Nurses to ensure current interventions are in place and communicated to staff at each shift change. Failure to comply with the education provided and implementing appropriate interventions will result in a disciplinary counseling by the immediate supervisor documented in the personnel record up to and including termination for the employee. This system will be monitored by the Director of Nursing Services at the morning clinical meeting five days weekly and the results reported to the Executive Director</p>		

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	<p>a mat. Resident #D's care plan had not been updated with the new intervention.</p> <p>6. Resident #E's record was reviewed 9/15/2011 at 4:15 p.m. Resident #E's diagnoses included but were not limited to dizziness, high blood pressure, and atrial fibrillation (a heart rhythm disturbance).</p> <p>Resident #E's nurse's notes indicated she had fallen from the bed on 8/22/2011 at 12:10 a.m.</p> <p>Resident #E 's fall care plan, dated 8/20/2011, included diagnosis of dizziness and interventions of observing for contributing factors, encouraging to use call light, referring to therapy, providing assistance for transfers, completing fall risk assessments, and providing assistive devices. Resident #E's care plan had not been updated with any interventions after her fall.</p> <p>In an interview on 9/15/2011 at 12:40 p.m., the MDS coordinator indicated care plan updates are to be completed by whom ever puts interventions into place. After a fall, care plans are reviewed at a meeting and the MDS coordinator is responsible for reviewing and updating the care plan.</p> <p>This Federal tag relates to Complaints</p>						

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F0323 SS=D	<p>IN00095560 and IN00096047.</p> <p>3.1-35(d)(2)(B)</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview and record review, the facility failed to ensure fall interventions were initiated to prevent falls for 3 of 6 residents reviewed for falls in a sample of 6. (Resident #B, Resident #D, and Resident #E).</p> <p>Findings include:</p> <p>1. Resident #B's closed short stay record was reviewed 9/15/2011 at 5:00 p.m. Resident #B's diagnoses included but were not limited to dementia, depression, and anxiety.</p> <p>Resident #B's nurse's notes, dated 6/28/2011 at 9:10 p.m., indicated Resident #B fell in the doorway of her room.</p> <p>Resident #B 's fall risk assessment included two assessments completed on 6/28/2011 and both indicated the resident was at risk for falls.</p>		F0323	<p>F323: Itti is ttihe practtice off ttihiis provider ttio implementti inttierventions consisttientiitt wittih ttihe residentti's,needs goals, plan off care and currentti sttiandards off practtice in order ttio reduce ttihe risk off an accidentti and ttio monittior inttierventions and modify ttihe inttierventions as necessary and according ttio currentti sttiandards off practtice</p> <p>1. Residentti B was admitted on June 28 ttihi , 2011 and discharged wittihin six hours off admission on June 28 ttihi , 2011</p> <p>Whatt correcttve actto(s) will be accomplished ffor tthese residentt fiound ttto be afiectted by tthe alleged deficientt practtce Residenttis D and E have been reassessed ffor Fall Risk ttihe Residenttis Comprehensive Care Plans updattd wittih currentti inttierventions wittih ttihe change implementtd by ttihe unitti nursing sttiafiAll fiacilittiy Residenttis Comprehensive Care Plans have been updattd and ttihe Inttierdisciplinary professional ttiem has mettii ttio review all inttierventions</p>		10/02/2011	

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	<p>Resident B's admission nurse's note, dated 6/28/2011, indicated Resident B was independently ambulatory.</p> <p>The fall circumstance report, dated 6/28/2011, indicated Resident B had been wearing nonskid socks.</p> <p>A review of care plans, dated 6/28/2011, for Resident #B revealed she was at risk for falls related to dementia, but the care plan did not include history of recent falls or interventions to prevent falls from occurring.</p> <p>The pre-admission screening, dated 6/17/2011, indicated Resident #B had fallen on 6/11/2011.</p> <p>In an interview with LPN #1 on 9/16/2011 at 9:09 a.m., she indicated the family had not indicated Resident #B was at risk for falls and had not fallen since January. She additionally indicated she had updated Resident #B's fall risk assessment when she had obtained additional information. When informed Resident #B had fallen on 4/4/2011, 4/28/2011 and 6/11/2011 at a previous residence, LPN #1 indicated she would have put more interventions in place to prevent falls.</p> <p>2. Resident #D's record was reviewed 9/15/2011 at 2:10 p.m. Resident #D's</p>				<p>related to this citation</p> <p>Resident's Care Plans attached</p> <p>How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All facility residents whom have potential for experiencing a Fall/accident have been reassessed for Fall Risk diagnoses, history current needs medication review therapy intervention and environmental factors have been evaluated and goals with intervention approaches identified The interdisciplinary professional team has met reviewed all factors and addressed intervention approaches on each care plan. The Nursing staff have been informed of any changes by updating the N.A. assignment sheets with current interventions the Resident's Comprehensive Care Plans and during each shift report system staff members are advised of new intervention Shift report is conducted by the Licensed Charge Nurse on each unit Resident Care Plans C.Q.I. audit tool will be used as a monitoring tool and completed by the Assistant Director of Nursing daily X5 (see attachment) weekly X4, and monthly X1 quarterly for 2 quarters If established thresholds are not met the results of this will be reviewed by the C.I. committee and Medical Director</p>		

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	<p>diagnoses included but were not limited to dementia, depression, and anemia.</p> <p>Resident #D's nurse's notes indicated he had fallen from his wheelchair on 8/23/2011 at 9:50 a.m.</p> <p>A review of Resident #D's nurse's notes indicated he had silenced the alarms on 8/22/2011 and 9/3/2011.</p> <p>A review of the fall circumstance report, dated 8/23/2011, indicated new intervention to be put into place was to cue Resident #D to lay down.</p> <p>Resident #D's fall care plan, dated 8/19/2011, included interventions of bed and chair alarms as well as a low bed with a mat. Resident #D's care plan had not been updated with the new intervention.</p> <p>Resident #D was observed up in his wheelchair on 9/15/2011 at 11:15 a.m., sleeping in his wheel chair during initial tour, then again between 12:40 p.m. and 1 p.m.</p> <p>During a continuous observation on 9/15/2011 between 3:50 p.m. and 5:20 p.m., Resident #D was observed up in the hall way in his wheel chair in various locations in the hall. Although staff engaged him in conversation, no staff</p>				<p>witth an Action Plan developed tto address ttiresholds In-services have been completted regarding Accident/Fall Prevention, Residentti Comprehensive Care Planning Policy and Procedure Review and Theraputtic Compensattory Inttierventions fior ttihe clinical sttiafi (See Attiachmenttjs</p> <p>Whatt measures will be putt into place or whatt systemic changes will you make tto ensure tthatt tthe alleged deficientt practtce does nott reoccur</p> <p>Sttiafi education has been completted and Unitti Managers,Licensed Charge Nurses are responsible fior daily and shifi rounds tto assess ttihe residenttis and ensure ttihe inttierventions are being implementted by line personnel. The education provided was as fiollows</p> <p>Accident/Fall Preventtion and Inttierventions provided fior Licensed Nurses/C.N.A.'s on 9/27, 9/28 and 9/29 provided fior all ttihee shifis (See attiachmenttis ofi ttiimes attendance conttientti wittih ttihe means tto assess learning attiestt(Fall risk assessmenttis have been completted on all fiacilittiy residenttis wittih ttihe pottentialt fior fialls</p> <p>Residentti Comprehensive Care Plan Policy and Procedure Review provided fior all Licensed Nurses Inttierrdisciplinary Team Member and Speech, Occupattional and Physical Therapisttis fior all shifiSee attiachmenttis ofi ttiimeattendance conttientti wittih ttihe means tto assess</p>		

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	<p>cued him to lay down or rest.</p> <p>In an interview on 9/15/2011 at 5:20 p.m., Resident #D indicated he had been up in his wheelchair all day.</p> <p>Resident #D's fall circumstance report, dated 8/23/2011, indicated he had been up in the hallway in his wheelchair for breakfast, and he stated he had fallen asleep in his chair.</p> <p>3. Resident #E's record was reviewed 9/15/2011 at 4:15 p.m. Resident #E's diagnoses included but were not limited to dizziness, high blood pressure, and atrial fibrillation (a heart rhythm disturbance).</p> <p>Resident #E's nurse's notes indicated she had fallen from the bed on 8/22/2011 at 12:10 a.m.</p> <p>Resident #E 's fall care plan, dated 8/20/2011, included diagnosis of dizziness and interventions of observing for contributing factors, encouraging to use call light, referring to therapy, providing assistance for transfers, completing fall risk assessments, and providing assistive devices. Resident #E's care plan had not been updated with any interventions after her fall.</p> <p>Resident #E was observed on 9/15/2011 at</p>				<p>learning/ttiestti</p> <p>Compensattory Inttierventions provided for Licensed Nurses and C.N.A.'s by ttihe Rehabilittiation Services Manager and Speech ttiherapistti 9/26, 9/27 and 9/28 for all shifis (See atttiachmenttis of ttiemes atttiendance conttiientti wittti ttihe means ttio assess learning/ttiestti</p> <p>During Shifi Changes ttihe Licensed Charge Nurses are responsible ttio communicattie ttihe inttierventions attti reportti ttio each oncoming shifi ofi care givers ttio educattie ttihe sttiatifi ttihey are responsible for supervising Updattied Q.N.A. assignmenttti sheettis will appropriattie inttierventions ttio preventti accidenttiffs Random unannounced rounds on each shifi ttio ensure compliance ofi ttihe inttierventions being addressed are required ofi every Licensed Charge Nurse on his/her assignmenttti The Residentti Comprehensive Care Plans will be updattied upon any change ofi condittion incidentti or accidentti or ottiher appropriattie inttierventtion added or discontinued by ttihe supervising nurse as necessary and reviewed attti ttihe Clinical Meetting conducttied five days weekly by ttihe Inttiinterdisciplinary professional ttiem</p> <p>How ttihe correcttve actto(s) will be monittored ttio ensure ttihe all deficientt practice will nott reoccur</p> <p>Residentti Care Plans Q.I. audittti ttiool will be utilitized as ttihe monittoring ttiool and complettied daily 5xweekly</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155788		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2011	
NAME OF PROVIDER OR SUPPLIER GREENWOOD MEADOWS, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 NORTH STATE ROAD 135 GREENWOOD, IN46142			
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	<p>11:17 a.m., during initial tour walking with her walker in the hallway. She was observed on 9/15/2011 at 12 noon, sitting in the dining area watching TV then walking with her walker out into the hallway.</p> <p>In a continuous observation on 9/15/2011 between 3:50 p.m. and 5:20 p.m., Resident #E was observed walking in the hall, in her room and in the dining room with her walker. She was wearing nonskid socks.</p> <p>Resident #E's fall circumstance report, dated 8/22/2011, indicated she had been restless earlier in the day and had been observed with her knees at the edge of the bed as if to crawl in. No new interventions were put into place respective to the fall.</p> <p>In an interview on 9/15/2011 at 12:40 p.m., the MDS coordinator indicated after a fall, the fall is reviewed at a meeting, interventions reviewed for appropriateness and adjusted according to the fall circumstance, and the care plan updated.</p> <p>This federal tag relates to complaint number IN00095560.</p>			<p>X4, and monttlihly X ttihan quarttlerly fior2 quarttlers lfi accepttttable ttihresholds are notti metti ttihe resulttis will be reviewed by ttihe Q.I. committtee and Medical Directtior wittih an action plan being developed and implemnettied Rounds conducttied by Licensed Charge Nurses on his/her assignmenttti ttio monittior ttihatti ttihese inttierventtions are in place and complettied each shifi The Inttiierdisciplinarry professional ttieam will ensure Residentti Comprehensive Care Plans are updattdied by ttihe supervising nurse upon change ofi condittionpincidentti or accidentti or ottiher appropriattie inttierventtions are in place ttihrough review attt ttihe Clinical Meeting conducttied five days weekly Failure ttio comply wittih ttihe educattion provided ttio keep residenttis safie from accidentti falls will resultti in a disciplinarry counselng by ttihe immediattie supervisordocumenttied in ttihe personnel recordup ttio and including ttierminattonThe Unitti Manager are responsible fior monittiorngsttiafi compliance reportting ttio ttihe Directtior ofi Nursing Services whom will be accounttiable fior monittiorng ttihe systtiems putt in place.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/07/2011

FORM APPROVED

OMB NO. 0938-0391

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	3.1-45(a)(2)						